INFORMED CONSENT STATEMENT FOR PERIODONTAL THERAPY

Please read the following information carefully. Risks associated with your periodontal therapy are explained below. Please take the time you need to ask all your questions before you sign.

Periodontal therapy can be required for a variety of reasons. These reasons include the persistence of periodontal pockets that make proper cleaning of the teeth and gums impossible, the presence of infection and the loss of bone support to the teeth. Periodontal therapy is performed to reduce or eliminate these pockets, remove unhealthy tissue and to thoroughly clean the root surfaces of the teeth. However, due to many factors such as advanced state of disease, lacke of adequate home care, nutritional or hormonal factors, etc., your problem may persist or even worsen with time and teth could be lost in the future.

It is important that you are aware that the success of your periodontal therapy is largely dependent on you. You must follow the instructions for home care very closely to get a good result. You should expect increased sensitivity of the tooth roots to cold, heat or sweets. This normally decreases over time, but the intensity and duration of discomfort vary greatly from person to person. Please be assured that we will use the utmost care in performing this procedure and have every reason to expect success.

I have read the above and have discussed with the Doctor the risks and treatment options of periodontal therapy. I understand that dentistry is not an exact science and no guarantee can be made to me. I hereby give my permission to proceed with the periodontal therapy.

Fee: _____

_____ _____

Date Signature of Patient

Please read and sign the following if you wish to decline the recommended treatment.

I have been warned of the consequences of refusing the periodontal therapy. I fully realize that this recommended treatment is needed. However, at this time, I cannot arrange for the needed treatment and release the Doctor and his/her staff completely of any responsibility for the resulting long-term ill effects.

_____ _____

Date Signature of Patient